



# GROUP PERSONAL ACCIDENT INSURANCE PROPOSAL FORM

AAR INSURANCE KENYA LIMITED  
GEORGE WILLIAMSON HOUSE, 4TH NGONG, 2ND FLOOR,  
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MPESA PAYBILL NO. 333200

## PART A: DETAILS OF THE PROPOSER

1. NAME OF PROPOSER \_\_\_\_\_
2. POSTAL ADDRESS \_\_\_\_\_ POSTAL CODE \_\_\_\_\_ TOWN \_\_\_\_\_
3. TELEPHONE NO. (OFFICE) \_\_\_\_\_ MOBILE NO. \_\_\_\_\_
4. EMAIL ADDRESS \_\_\_\_\_
5. PIN NO. \_\_\_\_\_ ID NO / CERTIFICATE OF INCORPORATION \_\_\_\_\_  
(Attach copy of each)
6. BUSINESS/TRADE/OCCUPATION \_\_\_\_\_

## PART B: RISK DETAILS

7. a) What are the highest emoluments paid to any one individual \_\_\_\_\_  
b) Is every person to be insured in good health and free from any mental defect or infirmity to the best of the proposer's knowledge and belief. Yes  No   
If yes please give details \_\_\_\_\_  
c) Is any person to be insured suffering from any physical defect or infirmity Yes  No   
If yes please give details \_\_\_\_\_  
d) Has any of them suffered from GOUT, DIABETES, PARALYSIS or FIT of any kind? Yes  No   
If yes please give details \_\_\_\_\_
8. Will any of the persons to be insured travel to a considerable extent by air or motor vehicle in the course of his or her duty Yes  No   
b) Do you have any boilers? Yes  No   
c) Are your works and or plant properly fenced and guarded and otherwise in good order/condition?  
Yes  No   
If yes to any of the above, please give details \_\_\_\_\_  
(Travel by Air shall mean travelling as a passenger in an aircraft operating on scheduled services)
9. Will any of the persons to be insured use machinery? Yes  No   
If yes, please give details \_\_\_\_\_
10. Has any Insurance Company or Underwriter ever :  
Cancelled your Policy? Yes  No   
Declined to insure you? Yes  No   
Refused to renew your Policy? Yes  No   
If the answer to any of the above is yes, please give details \_\_\_\_\_

11. Have you in the last 3 years suffered a loss in connection with the type of insurance

now proposed? Yes  No

If yes, please give details indicating the date of loss, nature of loss, amount of loss and cause of loss

**Schedule A: Insured persons for fixed benefits only**

NAMES OF PERSONS TO BE INSURED	DATE OF BIRTH	OCCUPATION	BENEFITS REQUIRED			
			DEATH	PERMANENT DISABLEMENT	TEMPORARY TOTAL DISABLEMENT	MEDICAL EXPENSES

**Schedule B: Insured persons for benefits based on wages or salaries.**

BUSINESS OR OCCUPATION OF INSURED	NUMBER	ESTIMATED GROSS TOTAL EMOLUMENTS PER ANNUM	BENEFITS REQUIRED			
			DEATH	PERMANENT DISABLEMENT	TEMPORARY TOTAL DISABLEMENT	MEDICAL EXPENSES

Please use separate list with similar format if the space provided is not sufficient.

Period of Insurance: From \_\_\_\_\_ to \_\_\_\_\_  
*Date /Month/Year* *Date/Month/Year*

Agency/Broker \_\_\_\_\_ Mobile No \_\_\_\_\_

**DECLARATION**

I/We declare and warrant that the statements given above are true and complete to the best of my/our knowledge and belief and I/We agree that this proposal and declaration shall be the basis of the proposed contract between the company and myself/ourselves and accept a policy on the usual company terms and conditions for this class of insurance.

DATE: \_\_\_\_\_  
*Date /Month/Year*

Signature of Proposer  
 Rubber Stamp/Seal.

Please do attach a copy of your PIN certificate, National Identification card/Passport and utility bill as per the "proceeds of crime and anti money laundering Act,2009" as acceptable proof of identity.

**Note: Liability does not commence until this proposal has been accepted and premium paid. It is also a condition of this policy that Estimated annual Wages, Salaries and other Earnings to be certified annually by your Auditors within three months of the expiry date of the period of insurance.**